MEDICARE SUPPLEMENTS
CHECKLIST FOR CODE 42

IDENTIFY POLICY & CERT PAGE #, OR LOCATION, OF BENEFIT WITHIN FORM SUBMISSION

REGARDING COMPLIANCE WITH REQUIREMENTS FOR MEDICARE PART D

- Amendments that drop coverage for outpatient prescription drugs from existing or in-force Medicare Supplement Plans must be submitted for review and approval.
- Filings of such amendments must include a signed and dated Actuarial Memorandum supporting a corresponding reduction in the premium rate.
- All such amendments, while appropriate for use with in-force plans, will be confusing when attached to new Medicare supplement policies and will not be approved for use with newly issued Medicare Supplement policies issued after January 1, 2006. If the filed amendment is not intended to be used with newly issued supplement plans, the filing should specify that this is the case.

60A.06 Kinds of Insurance Permitted

Subd 3 Limitation on Combination Policies

♦60A.08 Contracts of Insurance

Subd 5 Signatures Required

The signatures may be facsimile signatures and may be placed in brackets [] designating a "variable" item.

♦62A.02 Policy Forms

♦62A.021 Health Care Policy Rates

For health, we require proof of a reasonable loss ratio. Insurers must forward a signed actuarial memorandum for review.

♦62A.03 General Provisions of Policy

♦DENOTES A MANDATE FOR WHICH A SPECIFIC CONTRACTUAL REFERENCE IS REQUIRED.

MEDICARE SUPPLEMENTS
CHECKLIST FOR CODE 42

IDENTIFY POLICY & CERT PAGE #, OR LOCATION, OF BENEFIT WITHIN FORM SUBMISSION

♦62A.04 Standard Provisions (All Accident & Sickness Contracts)

Subd 2 Required Provisions

(4) Reinstatement

For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:

1. the insured has in the interim left the state or the insurer's service area; or

2. the insured has applied for reinstatement on two or more prior occasions.

Subd 10 Return of Premium

♦62A.043 TMJ and CMB Treatment

Applies only to group policies.

62A.044 Government Hospitals

62A.045 Welfare Benefits

62A.046 Coordination of Benefits

62A.049 Pre-Authorization Exceptions on Emergency Treatment

62A.081 Payments to Facilities Owned by State or Local Government

62A.141 Handicapped Dependents

Applies only to group policies

62A.145-.146 Continuation of Coverage for Survivor

MEDICARE SUPPLEMENTS CHECKLIST FOR CODE 42	IDENTIFY POLICY & CERT PAGE #, OR LOCATION, OF BENEFIT WITHIN FORM SUBMISSION

♦62A.149 Treatment for Alcohol and Drug Abuse

Insurers must make payments for treatment of alcohol and chemical abuse on the same basis as coverage for other medical services which are performed in (1) a licensed hospital, (2) a residential treatment program, (3) a nonresidential treatment program. The minimum amount of coverage for this benefit is described in Subd 2.

♦62A.152 Outpatient Mental Health

Applies only to group policies and subscriber contracts with at least 100 certificate holders.

♦62A.153 Ambulatory Surgical Center

62A.154 DES Related Conditions

♦62A.155 Ventilator Dependent

62A.18 Prohibition Against Disability Offsets

♦62A.20 Continuation Coverage of Current Spouse and Children

♦62A.21 Continuation of Coverage for Former Spouse

62A.22 Coverage for Work Related Injury or Sickness

♦62A.25 Reconstructive Surgery

♦62A.265 Coverage for Lyme Disease

♦62A.28 Scalp Hair Prosthesis

♦62A.30 Coverage for Diagnostic Procedures for Cancer

♦62A.302 Coverage of Dependents

The definition of dependent can be no more restrictive than that found in Minn. Stat. §62L.02.

♦62A.307 Prescription Drugs; Equal Treatment of Prescribers

♦62A.3093 Coverage for Diabetes

- Coverage must be provided for medically appropriate and necessary diabetic equipment and supplies for diabetes self-management training and education classes.
- The language "Necessary equipment and supplies" requires coverage of both oral and injectible insulin.

62A.31 Medicare Supplement Benefits: Minimum Standards

♦Subd 1 Policy Requirements

All individual and group policies, certificates, and subscriber contracts which offer Medicare Supplement insurance coverage to a resident of Minnesota must comply with provisions 1a to 1s. (Some requirements found on the Checklist)

♦Subd 1a Minimum Coverage

- 62E.07 Does not apply to Basic coverage.
- Extended Basic plans must always meet qualified coverage standards.

♦Subd 1b Pre-existing Condition Coverage

♦Subd 1c Limitation on Cancellation or Non-renewal

Subd 1d Mandatory Offer

Subd 1e Delivery of Coverage Outline

♦Subd 1f Suspension Based on Entitlement to Medical Assistance

♦Subd 1g Notification of Counseling Services

Subd 1h Limitations on Denials, Conditions, and Pricing of Coverage

If an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare Part B because the individual becomes enrolled under an employee welfare benefit plan, the individual is eligible for another six-month enrollment period, as provided in this subdivision, beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B. (effective 8-1-05)

Subd 1i Replacement Coverage

Subd 1j Filing and Approval

♦Subd 1k Guaranteed Renewability

Subd 1l Treatment of Sickness and Accident Losses

♦Subd 1m Medicare Cost Sharing Coverage Changes

Subd 1n Termination of Coverage

Subd 1o Refund or Credit Calculation

♦Subd 1p Renewal or Continuation Provision

Subd 1q Marketing Procedures

♦Subd 1r Community Rating

♦Subd 1s Prescription Drug Coverage

- Subject to MN Stat. 62A.31, subdivisions, 1k, 1m, 1n, and 1p, a Medicare supplement policy with benefits for outpatient prescription drugs, in existence prior to January 1, 2006, must be renewed, at the option of the policyholder, for current policyholders who do not enroll in Medicare Part D.

- A Medicare supplement policy with benefits for outpatient prescription drugs must not be issued after December 31, 2005.

♦Subd 1t Notice of Lack of Drug Coverage, as Amended in 2005

Supplement policies must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following notice:

> "Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details."

Subd. 1u. Guaranteed Issue for Eligible Persons.

Eligibility provisions amended pursuant to Chapter 17, Laws of 2005.

♦Subd 2. General Coverage

♦Subd 3. Definitions

♦Subd 4. Prohibited Policy Provisions

♦Subd 5. Advertising

♦Subd 6. Application to Certain Policies

MEDICARE SUPPLEMENTS CHECKLIST FOR CODE 42	IDENTIFY POLICY & CERT PAGE #, OR LOCATION, OF BENEFIT WITHIN FORM SUBMISSION

♦62A.315 Extended Basic Medicare Supplement Plan; Coverage

The minimum level of coverage is set by this section and by M. S. 62A.31, subdivisions 1 and 2. The requirements of M. S. 62E.06 and M. S. 62E.07 also apply.

- Must cover 50% for outpatient mental health services.
- Must cover 20% of the first $1,5000 for all physical therapy and occupational therapy services.
- Requires supplement to cover the copayment amounts of Medicare eligible expenses under Part B.
- Must cover outpatient medical and surgical services. (M. S. 62A.153)
- An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

♦62A.316 Basic Medicare Supplement Plan; Coverage

- In order for a plan to be considered a Basic Medicare Supplement Policy, it must offer at least the benefits contained in this section.
- Must cover 50% for outpatient mental health services.
- Must cover 20% of the first $1,500 for all physical therapy and occupational therapy services.
- Requires supplement to cover the copayment amounts of Medicare eligible expenses under Part B.
- Only the optional benefits riders listed under M. S. §62A.316 (b) may be added to a Basic Plan.
- Regarding Part B Riders pursuant to M. S. §62A.316 b(2):
  Part B Riders provide limited benefit for the Minnesota claims of

Minnesota residents. Filings that include Part B Riders must provide sufficient information to justify the rates for this limited benefit.

> [Due to the mandatory Medicare assignment law (M. S. §62J.25), a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare-approved amount for any Medicare-covered service provided.]

- An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

62A.317 Standards for Claims Payment

♦62A.318 Medicare Select Policies and Certificates

- This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations. No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

This may be a completely closed panel network.

- Coverage for outpatient prescription drugs is not permitted in Medicare supplement policies or certificates issued on or after January 1, 2006.

62A.319 Reporting of Multiple Policies

♦62A.36 Loss Ratio Standards

62A.37 Government Seals and Emblems prohibited

♦62A.38 Notice of Free Examination

MEDICARE SUPPLEMENTS
CHECKLIST FOR CODE 42

IDENTIFY POLICY & CERT PAGE #, OR LOCATION, OF BENEFIT WITHIN FORM SUBMISSION

♦62A.39 Medicare Supplement Disclosure Requirements:

The outline must contain the required disclosures of information in no less than 12-point type is delivered to the applicant at the time the application is made. Two of the eleven items are noted below:

Outline of Coverage Forms**:**

A statement of the renewal provisions including any reservations by the insurer of a right to change premiums. The premium and manner of payment shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

Requirement for Medicare Supplement Outline or Application**:**

A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of (..%). This means that, on the average, policyholders may expect that ($....) of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.".

62A.40 Replacement Regulated

62A.41 Penalties

62A.43 Limitations on Sales

62A.436 Commissions

Requires a level commission for each of the first four years of the policy

62A.44 Application

Subd 1 Applicant Copy

♦Subd 2 Questions

♦62E.07 Qualified Medicare Supplement Plan

♦DENOTES A MANDATE FOR WHICH A SPECIFIC CONTRACTUAL REFERENCE IS REQUIRED.

- Required by the first sentence of 62A.315 and 62A.315, Subd 1a.
- Applies to Extended Basic plans only.
- Must provide 100% of the Medicare deductibles.
- Must cover 80% of the charges up to an out of pocket expense of $1,000 annually. Then, must provide 100% coverage.
- Refer to 62E.06, subd 1 for a description of the covered services that are required.

62J.25(d) Mandatory Medicare Assignment

62Q.471 Exclusions for Suicide Attempts Prohibited.

♦62Q.50 Prostate Cancer Screening

♦62Q.525 Coverage for Off-Label Drug Use

♦62Q.53 Mental Health Coverage

This law provides for minimum standards for medically necessary care by including a minimum definition for "medically necessary care". Medically necessary care must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

[Note: In addition, both the in basic and extended basic must cover the 50% for outpatient mental health services.]

62Q.535 Coverage for court-ordered mental health services.

♦62Q.56 Continuity of Care (Medicare Select Only)